Patient Safety Innovation Award - 2019 Nomination Form

For questions about submitting a nomination for the award, contact Casey Hutchens chutchens@IHAconnect.org.

Overview

The Indiana Patient Safety Center (IPSC) has established the annual Patient Safety Awards to recognize individuals, groups and organizations who have helped bring Indiana closer to the goal of zero patient harms. These awards will honor commitment and enthusiasm for improving patient safety in hospitals and communities across the state.

The Patient Safety Innovation Award recognizes an individual, group or program that has developed innovative ways to improve, encourage or enhance patient safety within their hospital, health system, regional patient safety coalition or professional organization. This could mean developing a new program, process or campaign or leveraging an existing process or tool in a new way. Winners will demonstrate creativity and forward thinking.

Submit your nomination by filling out the following form and submitting a brief narrative. Supporting documents may be attached to enhance your nomination.

The nomination period is open from Feb. 25 to April 8. Nominations will be carefully considered by a committee of health care professionals and patient safety advocates, with winners announced at the Patient Safety Summit June 4.

2018 Winner: The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital

The Comprehensive Transitions of Care (TOC) Pharmacy Program at Franciscan Health Hammond Hospital received the 2018 Patient Safety Innovation Award for their outstanding work improving continuity of care medication safety by targeting high-risk patients to receive a TOC pharmacist evaluation of patient's medication therapy. Through this unique approach to patient care, the team at Franciscan Health Hammond Hospital removed patient care silos by bridging the gaps in care in all aspects of a patient's healthcare experience. The Comprehensive Transitions of Care (TOC) Pharmacy Program was created to bridge gaps in transition of care from the hospital to home and, ultimately, decrease hospital readmissions of high-risk patients.

2019 Nomination Form

NOMINATOR INFORMATION

Name *

Lisa Leckrone

Job Title *

Director Quality and Risk Management

Hospital/Organization *

St. Mary Medical Center

Address *

1500 S Lake Park Ave Hobart

Email *

lisa.r.leckrone@comhs.org

Phone Number *

219-947-6189

NOMINEE INFORMATION

I am nominating a(n) *

- ○ Individual
- ◉ Group/Team/Coalition
- ○ Organization

If group, team, coalition, or organization, please include name

Multi Professional Care Coordination To Improve Outcomes

Contact Name *

Lisa Leckrone

Job Title *

Director Quality and Risk Management

Hospital/Organization *

St. Mary Medical Center/St. Mary Home Health

Address *

1500 S Lake Park Ave

Email *

Lisa.r.leckrone@comhs.org

Phone Number *

219-947-6189

NOMINATION REASONING

Please write a brief narrative below that describes why this nominee deserves to be recognized. Please incorporate the answers to the following questions in your narrative based on the award you indicated above.

Write response here *

This multi-professional team includes, nursing, pharmacy, care navigators, quality, home health, education, accountable care organization representative, and physician leaders along with the patient and family advisory committee to improve health outcomes and reduce healthcare utilization. The team analyzes which patients need additional resources based on social determinants and diagnosis history. Bringing care to the patients within their home environment or within an outpatient Heart Failure/Pulmonary Disease Clinic within the hospital.

PATIENT SAFETY INNOVATION AWARD

Please complete all questions below.

What patient safety initiative has this individual/group/organization created or led? *

This group has focused on the high volume diagnosis's of heart failure and chronic obstructive pulmonary disease. Successful transitions from our patients perspective identified a need for them to feel prepared and capable to care for themselves post discharge and clear accountability from the healthcare system along with ensuring they felt care about during the transition to the post acute setting.

What need did this initiative fill, or what problem did it solve? *

The need was to reduce healthcare utilization of multi-visit patients with chronic disease conditions, identifying social determinants, ensuring evidence based care was provided in the acute setting along with understanding the patient perspective and barriers they have to meeting their healthcare needs post discharge.

What made this initiative innovative or unique from existing efforts? *

Several initiatives are 1. Knowing who to contact when patients have a question post discharge with a quality care navigator that follows them for 12 months 2. Partnering with our home health agency to work together and share data and information within the electronic medical record 3. Participating in a national research project to obtain the patients perspective in what they need post discharge to be successful 4. Identification of what population to focus on by analyzing data on emergency room and inpatient utilization 5. Connecting patients with the appropriate healthcare provider timely after discharge.

What results did this initiative produce? *

Reduction in readmissions and mortality rates better than national rates for heart failure and same as national for COPD.

Has this innovative initiative been recognized by other individuals or groups, or has it been replicated by others since its implementation? *

No

This content is neither created nor endorsed by Google.

Google Forms